MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
DIVISION OF SPECIAL EDUCATION, PO BOX 480, JEFFERSON CITY, MO 65102
FUNDS MANAGEMENT SECTION

**MEDICAID BILLING INITIATIVE APPLICATION**

| **SCHOOL DISTRICT NAME** | **COUNTY/DISTRICT CODE** |
|---|---|
| | |

| **DISTRICT CONTACT** | **CONTACT PHONE NUMBER** | **CONTACT EMAIL ADDRESS** |
|---|---|---|
| | | |

**SUMMARY:** Funds are available to eligible districts to promote participation in billing Medicaid for reimbursable costs.

These grants represent an opportunity for eligible districts to receive "seed" funding to build the capacity to bill Medicaid for reimbursements for both Direct Services and School District Administrative Claiming. Participation in Medicaid billing typically yields significant federal reimbursement amounts, so that once billing processes are in place, reimbursement receipts can continue to support the district's cost to do the billing.

**ELIGIBILITY:** Districts not currently participating in billing Medicaid, and who have not previously received funds from this grant are eligible to apply for these funds.

**CURRENT LEVEL OF MEDICAID BILLING:**

Briefly describe the district's current level of participation in Medicaid billing.

(Yes/No) _____ Actively bill for Direct Services (e.g., OT, PT).

(Yes/No) _____ Currently bill for School District Administrative Claiming (SDAC)

**PROPOSED MEDICAID BILLING INITIATIVE.** Briefly describe what you intend to do with the grant. Attach additional pages if necessary. Indicate estimated Medicaid eligible students receiving reimbursable services.

**PRESENTATION OF ESTIMATED COSTS**

**1. PERSONNEL COSTS**

| | **Function of person(s) in the project** | **Salary & Benefit Costs** | **Explain if Prorated** |
|---|---|---|---|
| | | $ | |
| | | $ | |
| | | $ | |
| | | **SUBTOTAL** | $ |

| | | |
|---|---|---|
| 2. | **PROFESSIONAL DEVELOPMENT COSTS**<br>(Describe why this is a specifically required and what P.D. activity(ies) will be received.) | $ |
| | | |
| 3. | **SPECIALIZED EQUIPMENT/SOFTWARE**<br>(Provide a brief description and justification for the purchase of all specialized equipment and/or software that will be acquired as part of the proposed initiative.) | $ |
| | | |
| 4. | **PROFESSIONAL SERVICES**<br>(Provide a brief description and justification for all professional services currently planned as part of the proposed initiative.) | $ |
| | | |
| 5. | **OTHER**<br>(Provide a brief description and justification for any other anticipated expenditures planned as part of the proposed initiative.) | $ |
| | | |
| **SUM OF COSTS FOR THE PROPOSED MEDICATD BILLING INITIATIVE (SUM PARTS 1 TO 5)** | | $ |

**CERTIFICATION STATEMENT:** I CERTIFY THAT THE EXPENSES LISTED HEREIN HAVE BEEN MADE SOLELY ON BEHALF OF THE APPLYING SCHOOL DISTRICT, MEET ELIGIBILITY AND APPROVAL REQUIREMENTS, AND WILL BE USED WITH THE INTENT TO START AND CONTINUE BILLING MEDICAID FOR DIRECT SERVICES AND SCHOOL DISTRICT ADMINISTRATIVE CLAIMING (SDAC) COSTS.

| **PERSON COMPLETING FORM** | **POSITION** | **TELEPHONE NUMBER** |
|---|---|---|
| | | |

| **SIGNATURE OF SUPERINTENDENT** | **DATE SIGNED** |
|---|---|
| | |

**STATE OFFICE USE ONLY**

| **APPROVED AMOUNT OF MEDICAID BILLING INITIATIVE TO LEA** | $ |
|---|---|
| **SIGNATURE OF DIRECTOR, FUNDS MANAGEMENT SECTION** | **DATE SIGNED** |